BabyCare

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Fall 2008

- Do you normally assess for high risk factors with your clients when you meet with them?
- Do you make follow up phone calls to your clients after an appointment?
- Do you see your clients if they come to the health department for clinic visit or WIC visit?
- Do you help them schedule their prenatal or well child visit?

BabyCare

BabyCare

- Overview and Purpose
- Eligibility
- MICC Services
- Documentation Requirements
- Billing Tips
- Medicaid Managed Care Organizations
- Expanded Prenatal Services
- Basic Eligibility for Pregnant Women

Overview of BabyCare

- High risk pregnant mothers and high risk infants may receive intensive case management services referred to as Maternal and Infant Care Coordination (MICC).
- Pregnant mothers are eligible for additional services called “Expanded Prenatal Services”.

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Overview of BabyCare cont.

- BabyCare is available for high risk pregnant women and infants who are enrolled in a DMAS Fee-for-Service program.
- Medicaid Managed Care Organization have their own high risk maternity and infant programs.

The Purpose of BabyCare

- To improve birth outcomes,
- To reduce infant mortality and morbidity,
- To ensure provision of comprehensive services to pregnant women and infants up to age two, and
- To assist pregnant women and caretakers of infants in receiving wrap-around services that affect their well-being and that of their families.

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BabyCare Eligibility

- Pregnant Women - eligible during pregnancy and through the end of the month that the 60th day post partum falls.
  - Note: System auto-ends MICC eligibility on the 5th of the month after 60th day post partum period
    - If her 60th day falls on the 1st through 5th of month, and you still have her open through the end of that month, notify MCH to re-authorize services through the end of month of 60 day post partum
  - Upcoming MMIS change: Model after DMAS eligibility coverage – through the end of the month that the 60th day postpartum period falls.
- Infants up to age 2 (actual 2nd birthday)

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Referrals for BabyCare

- Qualified Provider completes Risk Screen
  - Physician
  - Physician Assistant
  - Nurse Practitioner
  - Certified Nurse Midwife
- *Possible to have RN or Social Worker complete Risk Screen and have practitioner sign off – depends on your agency policy and practitioner.*

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Referrals for BabyCare cont.

- Risk Screens include:
  - Maternal Risk Screen DMAS 16
  - Infant Risk Screen DMAS 17
- Required for enrollment/reimbursement:
  - Maternal Infant Care Coordination
  - Certain Expanded Prenatal Services

Risk Screen

- Required fields for reimbursement:
  - Patient's name
  - 12 digit Medicaid/FAMIS ID number
  - EDD (pregnant women only)
  - At least one high risk indicated
  - Appropriate referral checked
  - Signed and dated by approved provider with their National Provider Identifier (NPI)
- Send referral to BabyCare provider.

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Maternal Infant Care Coordination (MICC)

Fee-For-Service Medicaid,

FAMIS Plus, FAMIS and
FAMIS MOMS

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What is MICC?

- Maternal and Infant Care Coordination (MICC) is an intense care coordination/home visitation program for pregnant women and infants up to age two.
- *Services that bridge individuals to resources to help them achieve a healthier pregnancy, more positive birth outcomes and healthier infants.*

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MICC Coordinator Provider Requirements

Services are provided by:

- Registered Nurse – must be licensed in VA and have a minimum of 1 year experience in community health nursing
- Social Worker – B.S.W. or M.S.W. and a minimum of 1 year experience in a health care setting
- Must be enrolled with the Department of Medical Assistance Services

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What is MICC?

- Service elements include the risk screen, assessment, service planning, coordination and referral, follow-up and monitoring, and education and support services.
- ***Case management services only.***

Case Management Services

- CM assists individuals to gain access to needed medical, social, educational, and other services.
- CM services and activities include:
  - Assessment and Reassessment
  - Developing a Service plan
  - Referrals and coordinating services
  - Monitoring and follow up
  - Education and counseling

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MICC Enrollment Process

- Receipt of Risk Screen completed by qualified practitioner

- Verify eligibility for Medicaid, FAMIS, FAMIS Plus, FAMIS MOMS

MICC Enrollment Process

- If in FFS:
  - Forward Risk Screen and MICC Record to DMAS/BabyCare
  - NEW! Will receive prior auth via postal mail for dates of services on or after 11/1/08
  - DOS prior to 11/1/08 will receive secure email notification.

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CPR545
AS OF:10/29/2008
RUN DATE: 10/30/2008 02:17

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
PRE-AUTHORIZATION NOTIFICATION

REPORT NO: CP-0-448-01
PAGE NUMBER: 1

PATRICK CNTY HLTH CLINIC
P O BOX 428
STUART VA 24171-0428

FOR PROVIDER NUMBER [redacted]

PA REQUEST ACTIVITY FOR: 10/30/2008

Preauthorization does not guarantee that payment will be made for the items or services authorized in this report. Reimbursement is contingent upon both the enrollee's eligibility status at the time the service is rendered as well as the provider's enrollment status with DMAS at the time the service is rendered. Reimbursement amounts are subject to change based on federal and state fee adjustments. If no dollar amount is shown, payment will be made in accordance with DMAS established reimbursement policies.

PA#: [redacted] ENROLLEE NAME: [redacted] ENROLLEE#: [redacted]

The following request(s) for preauthorization were approved and may be billed to DMAS.

PROCEDURE/ MODIFIER	DESCRIPTION	REQ UNITS/PER	REQ DATES FR/THRU	AUTH UNITS/PER	AUTH DATES FR/THRU	APPROVED COST/UNIT
G9002 00	COORDINATED CARE FEE, MAINTENANCE R	273 YR	11/01/2008 07/31/2009	273 YR	11/01/2008 07/31/2009	0.00

REASON CODES 1010: SERVICE IS MEDICALLY NECESSARY AND APPROVED AS REQUESTED.

**** CONFIDENTIAL INFORMATION **

Revised!

Initial Contact

- Collateral contact must be made within 15 calendar days from date referral was received.
- Collateral contacts include:
  - Contact with the client, primary care provider, client's significant others

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Revised!

Home Visit

- Home Visit completed within:
  - 30 days for infant client
  - 90 days for maternal client
- MICC recommends assessing client in home environment
- DMAS will accept other setting, however document reason why home visit did not occur.

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NEW! Initial Face-to-Face Contact

- A 30 day extension is granted if unable to complete initial face-to-face contact.
- If unable to establish initial face-to-face contact after 60 days, case must be closed.
- Complete sections #21 and #81 on DMAS 50 and send to DMAS for prior authorization to bill for period of initial contact attempts to date closed.

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Initial Face-to-Face Contact cont.

NEW!

- Refused Enrollment?
  - Complete DMAS 50 section #21, 81, and 82 and send in with Risk Screen for prior authorization to bill for care coordination during time spent to engage client

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Monthly Care Coordination

- For monthly care coordination billing
  - If face-to-face contact is not successful, must show documentation of collateral contacts
  - Minimum of one contact per month

Monthly Care Coordination cont.

- Home visits, face-to-face in other settings, telephonic or collateral contacts meets minimum monthly to bill for care coordination.
- Visit schedule will need to meets needs of client identified in Service Plan.

Revised!

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NEW! Closing Client to MICC

- Unable to establish successful contact during a month, one month extension granted.
- If unable to establish successful contact after 60 days, close client.
- May bill for time that good faith effort is documented to try to establish contact with client, through close date.

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Closing Client to MICC cont.

- Maternal: Through the end of the month of the 60th day postpartum
- Infant: Infant reaches age 2
- Individual enters MCO
- Goals met (no longer need for service)
- Drop out of program/request to close
- No longer meets criteria
- Client moves out of service area

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Closing Client to MICC cont.

- The MICC provider needs to ensure a smooth discharge or transition by:
  - Making the appropriate referrals
  - Providing information to the MCO, other MICC agency or other community resources (i.e., case manager).
- Begin termination process/transition early!

Documentation Requirements

- Identify client on each entry
- Document all successful and attempted contacts (face-to-face, telephonic, collateral)
- Short description of activity
- Sign and date each entry
- Evidence that PCP is aware of MICC services

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Documentation Requirements cont.

- Timeline for obtaining services and reevaluation (Service Plan)
- DMAS not requiring documentation of total billable minutes
  - Moratorium is scheduled for execution on April 1, 2009, but implementation of the 15 minute rule may be delayed.
  - DMAS will notify case management providers of new developments.

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Documentation Requirements cont.

- MICC Begin date – Date MICC coordinator initiates first contact
  - Section #21 of DMAS 50
- Complete Service Plan (DMAS-52) or equivalent
  - Keep in medical record
- Complete Letter of Agreement (DMAS-55)
  - Keep in medical record
- Progress Notes

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Billing Tips

- Risk Screen (99420)
  - 1 unit = 1 completed Risk Screen
    - Limit of 5 per pregnancy, per provider/site (DMAS-16)
    - Limit of 2 per child, per provider/site, every 11 months (DMAS-17)
  - Does not need to be open to MICC to be reimbursed for Risk Screen

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Billing Tips cont.

- MICC Assessment (G9001)
  - 1 unit = 1 complete assessment (DMAS 50)
  - Does not need to be open to MICC to be reimbursed for MICC Assessment
  - Limit of 2 units, per provider/site, every 11 months

Billing Tips cont.

- Care Coordination (G9002)
  - 1 unit = 1 day
  - Requires Prior Authorization beginning DOS 11/1/08
  - Enter PA # on claim form

Billing Tips cont.

- Mileage (S0215)
  - 1 unit = 1 mile
  - Only billable if successful face-to-face visit completed
  - Bill with care coordination during same time period (bill G9002 first on claim)

Billing Tips cont.

- Refused Enrollment/Unable to enroll client?
  - Complete DMAS 50 section #21, 81, and 82 and send in with Risk Screen for prior authorization to bill G9002 for time spent to engage client
  - Assessment (G9001) can be billed only if successful face-to-face assessment completed.

NEW!

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Changes

Old

- Initial contact required within 10 days and must be home visit
- Could not open without home visit being completed.

New

- Initial contact must be completed within 15 calendar days and may be collateral.
- Recommend initial home visit assessment:
  - 30 days for infant
  - 90 days for maternal

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Changes cont.

Old

- Home visit required monthly to bill for care coordination.

New

- Minimum monthly contact to bill for care coordination and includes:
  - Home visit
  - F-to-F visit in other setting
  - Telephonic
  - Collateral

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Changes cont.

Old

- No policy on how long to attempt to engage client prior to closing case.

New

- Can't establish contact one given month? 30 day extension granted.
- Close after 60 days of unsuccessful contact.
  - Documentation of good faith attempts – may bill for G9002

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Changes cont.

Old

- Care coordination rate: $1.35 per day

- Mileage rate: $0.22 per mile

New – as of…

July 1, 2007

- Care coordination: $4.05 per day

Feb. 1, 2007

- Mileage rate: $0.49 per mile

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Managed Care Organizations

High Risk Maternity and Infant Programs

Managed Care Organizations

- MCOs have their own high risk maternal and infant programs; however, some contract out with other agencies for high risk case management services.
- Must provide or arrange for services for pregnant women and children up to age 2 which are comparable to the Virginia Administrative Code (VAC).

www.dmas.virginia.gov/downloads/pdfs/mc-MedallionII_cntrct.pdf

Virginia Administrative Code

- 12 VAC 30-50-410
  - Case management services for high risk pregnant women and children.
- 12 VAC 30-50-510
  - Expanded Prenatal Care services.

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Managed Care Organizations (MCO)

- DMAS's BabyCare providers may only bill the MCO if they are contracted with the MCO to be a provider.
- MCOs may typically handle low risk via telephonic case management and refer out for higher risk clients.
- Contact the MCO directly to negotiate contract if not already a provider.

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Transfer from FFS to MCO

- What happens when we have prior authorization and the MICC client enrolls in an MCO?
  - Begin transition/termination process early
  - Work with MCO case manager to help establish rapport with client
  - Continue services if contracted with MCO and receive MCO authorization

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Transfer from FFS to MCO

- Complete Change Form (DMAS-56) and submit to DMAS when there is a change from FFS to MCO or vice versa
- DMAS to work on monthly notification to providers as well as the MCOs which will include MICC enrollees who have been preassigned to MCO

Why bother with FFS?

- Newly enrolled individuals can take about 60 days to transition to an MCO.
- You have greatest impact on these individuals seeing them early/prior to enrolling in MCO.
- Why not get reimbursed for services that you may already be doing?

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Why bother with FFS?

- Example of revenue for 60 days of FFS MICC:
  - Risk Screen – average $7.00
  - MICC Assessment - $25.00
  - Care Coordination – 60 x 4.05 - $243.00

    Potential Revenue: $275.00
- Additional revenue

  Mileage – $0.49 per mile for successful visits

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Why bother with FFS?

- Are you assessing risks on every client?
  - Bill for the Risk Screens!
  - Complete demographic, check risk, sign and date, enter NPI
  - Attach to claim form (CMS-1500) for payment
  - Up to 5 per maternal client
  - Up to 2 per infant client
  - Batch check eligibility for up to a year after date of service

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Why bother with FFS?

- If provider not contracted with the MCO, it is suggested the case manager communicate with the MCO case manager assigned to initiate smooth transition and ensure appropriate services are being delivered upon transition.

Expanded Medicaid Services for Pregnant Women

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Expanded Medicaid Services for Pregnant Women

- Patient Education
  - –S9442 and S9446
- Nutrition Services
  - –97802 and 97803
- Homemaker Services
  - –S5131

Patient Education

- Patient Education
  - Childbirth classes (S9442)
  - Smoking cessation (S9446)
  - Parenting classes (S9446)
- Limit 6 each code, per pregnancy per provider
- DMAS allowing for individual or class sessions
- Billable up to 60 days postpartum
  - For example: Car seat safety classes done with post partum woman – billable to DMAS

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Patient Education cont.

Revised!

- Instruction must be rendered by DMAS approved providers who have appropriate education, license, or certification.
  - New: Auto-approve VDH employees and educational classes
- No risk screen required! NEW!
- *Possible to back bill for up to one year for Patient Education services if no risk screen obtained*

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Nutritional Services cont.

- Specialized Nutritional Services include:
  - Nutritional Assessment (limit of 1)
  - Nutritional Counseling (limit of 1)
  - Counseling Follow Up (limit of 1)
- Provider must be Registered Dietician (R.D.) or person with a masters degree in nutrition or clinical dietetics.
- *Utilize the RDs in the WIC clinics!*

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Nutritional Services

- All pregnant women are expected to receive basic nutrition information from their medical care providers and/or the WIC program.
- No prior authorization required
- Must submit Maternity Risk Screen attached to claim for Nutritional Assessment (97802) and Nutritional visit (97803)

Homemaker Services

- Includes those services necessary to maintain household routine for pregnant women, primarily in third trimester, who require bed rest
- RN or LPN must provide supervision to the homemaker aides.
- Homemaker duties may be performed by a companion, homemaker, nursing assistant or home health aide.

Pregnant Women's Medical Assistance Programs

Overview of DMAS Eligibility

Pregnant Woman Medicaid and FAMIS MOMS

- Virginia has two medical assistance programs specifically for pregnant women.
- These programs provide comprehensive health care for pregnant women through end of month of 60 day postpartum.
  - Medicaid
  - FAMIS MOMS

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Pregnant Woman
Medicaid and FAMIS MOMS

- *Eligibility Begin Date*
  - Medicaid for Pregnant Woman – up to 3 months prior to month of application
  - FAMIS MOMS – month of application
- Income Limits
  - Medicaid for Pregnant Women - 133% FPL
  - FAMIS MOMS – 185% FPL

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Income Guidelines as of 7/1/08

#in family	133% FPL Plan First FAMIS Plus Medicaid Pregnant Woman	185% FPL FAMIS MOMS	200% FPL FAMIS
1	$1,153	n/a	$1,734
2	1,552	2,159	2,334
3	1,951	2,714	2,934
4	2,350	3,269	3,534
5	2,749	3,824	4,134
6	3,148	4,379	4,734
7	3,547	4,934	5,334
8	3,946	5,489	5,934

Enrollment of Children

For quarter 4/1/08-6/30/08:

- Under age 1 = 42,383
- 1 to 2 years of age = 67,290

Total: 109,673

- 6,100 enrolled in Medallion PCP
- 32,500 enrolled in straight FFS

Enrollment of Pregnant Women

As of December 1, 2008

- FAMIS MOMS – 1,172
- Medicaid for Pregnant Women – 16,486

Total – 17,658 pregnant women covered

**Maximize your DMAS funds – retroactively bill up to one year from DOS*

***Remember…*

Medicaid enrollees are always FFS first!

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Enrollment in Managed Care 101

- Determined to be eligible for Medicaid; DSS enters into system
- 15-45 days after eligibility entered into system, pre-assignment takes place
- *FAMIS does not have pre-assignment. FAMIS enrollees are assigned a plan immediately but have 90 days to make a change.*

MCO Pre-assignment

- Notified by letter
- All clients are pre-assigned to a MCO
- Must call to make selection by deadline
- No call = enrollment into pre-assigned MCO
- Obtain services through fee-for-service (regular Medicaid) until MCO is effective

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MCO Pre-assignment timeline example

- DSS enters eligibility in system prior to 18th of December
- Recipient pre-assigned on December 18 system run
- Letter mailed to recipient end of December
- Asked to call Managed Care Helpline by January 18 (or the Friday before if the 18th falls on a weekend) to make selection

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MCO Pre-assignment timeline example

- Recipient does not call by January 18, enrolled in pre-assigned MCO effective February 1st
- Recipient calls on or before January 18 to make selection, enrollment effective February 1st
- Recipient calls to select/change MCO between January 19 – February 18, selection/change effective March 1st

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Medicaid - Changing MCOs

- 90 days after effective date to change MCOs for any reason
  - Before 18th of month, effective 1st of following month
  - After 18th of month, enrollment delayed another month
- After 90 days change allowed with approval from DMAS for good cause
- Annual Open Enrollment – change MCOs for any reason
- FAMIS enrollees do not have Open Enrollment. They may change plans on their annual renewal date.

60-day Re-enrollment to MCO

- Member loses Medicaid eligibility = MCO enrollment ends
- Re-gains Medicaid eligibility within 60 days
  - Automatically re-enrolled in previous MCO
  - Notified by letter

Newborn Enrollment in MCO

- Born to MCO-enrolled mom
  - Baby covered by mom's MCO for birth month plus 2 more months
- Mom can change MCO if ID # on file
- Mom should report birth to DSS ASAP
- No Medicaid ID# for baby at end of 3rd month = loss of coverage
- Babies born to FAMIS MOMS enrollees are not guaranteed coverage

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Always Check Eligibility

- Providers must verify eligibility at each point of service.
- http://virginia.fhsc.com
  - Automated Response System: Allows for *batch process* to check recipients eligibility
    - Check for initial date services provided
- MediCall
    - 1-800-884-9730
    - 1-800-772-9996

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Examples

- Client being seen in OB Clinic or WIC clinic?
  - Schedule time to see them at the clinic visit
  - Complete Risk Screen and MICC Assessment
  - Open to MICC once DMAS eligibility confirmed and back bill up to begin date of eligibility and date of MICC assessment.
- Person came in for pregnancy test?
  - Risk Screen, bill once DMAS eligibility confirmed

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Examples

- Newborn 2 week checkup?
  - Risk Screen
  - MICC assessment
  - Open to MICC once DMAS enrollment confirmed ~ remind to enroll baby with DMAS
- Infants born to undocumented mothers can end up being covered by Medicaid/FAMIS Plus/FAMIS.
  - Meet citizenship requirements being born in U.S.

- New BabyCare provider manual available on web at www.dmas.virginia.gov
  - Under Provider Manuals

- Also have BabyCare section on DMAS website under Maternal and Child Health

http://www.dmas.virginia.gov/ch-home.htm#BabyCare

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BabyCare Contacts

DMAS/Maternal and Child Health Division

BabyCare

600 East Broad Street, Suite 1300

Richmond, VA 23219

Phone: 804-786-6134

Fax: 804-225-3961

Email: MICC@dmas.virginia.gov (do not send PHI – not a secure line)